Supreme Court, U.S.
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92-463

No.

IN THE

Supreme Court of the United States

OCTOBER TERM, 1992

UNITED CEREBRAL PALSY ASSOCIATIONS OF NEW YORK STATE, INC.,

Petitioner,

vs.

MARIO CUOMO, as Governor of the State of New York; ELIN HOWE, as Commissioner of the New York State Office of Mental Retardation and Developmental Disabilities; LORNA McBARNETTE, as Acting Commissioner of the New York State Department of Health; GREGORY M. KALADJIAN, as Acting Commissioner of the New York State Department of Social Services; PATRICK BULGARO, as Director of the New York State Division of the Budget,

Respondents.

PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether the Boren Amendment to the Medicaid Act is violated when a state, for budgetary reasons, enacts a permanent Medicaid reimbursement payment lag to health care providers, resulting in a reduction of payments to those providers such that the resulting annual reimbursement rates for the period in which the delay occurs falls below those determined by the state to be reasonable and adequate to meet the costs incurred by the providers?

2. Whether, pursuant to Wilder v. Virginia Hospital Association, the fundamental obligation of a state under the Boren Amendment to the Medicaid Act, to make payments for services rendered by providers through the use of rates that

are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities, is met when a state determines those rates but then, for budgetary purposes, permanently lags payment to the providers based upon those rates?

3. Whether a state's unilateral institution of a permanent lag in Medicaid payments based upon rates previously determined to be reasonable and adequate constitutes a "change in payment methods and standards" for which the state is required to make findings and assurances to the Secretary of the Department of Health and Human Services?

4. Whether a state's unilateral institution of a policy of permanently delaying Medicaid payments to providers is

a "material change in state law, organization, or policy, or in the state's operation of the Medicaid program" for which the state is required to promptly amend its State Plan for Medicaid?

LIST OF PARTIES

The parties to this action in the United States District Court for the Northern District of New York, and the United States Court of Appeals for the Second Circuit, are as follows:

UNITED CEREBRAL PALSY ASSOCIATIONS OF NEW YORK STATE, INC., Plaintiff-Appellant, and

THE ST. LUKE'S- ROOSEVELT HOSPITAL CENTER, Intervenor-Plaintiff-Appellant,

v.

MARIO CUOMO, as Governor of the State of New York; ELIN HOWE, as Commissioner of the New York State Office of Mental Retardation and Developmental Disabilities; LORNA McBARNETTE, as Acting Commissioner of the New York State

Department of Health; GREGORY M. KALADJIAN, as Acting Commissioner of the New York State Department of Social Services; PATRICK BULGARO, as Director of the New York State Division of the Budget, Defendants-Appellees.

Pursuant to Supreme Court Rule 29.1, petitioner states that United Cerebral Palsy Associations of New York State, Inc. is a New York not-for-profit corporation having no parent companies or subsidiaries.

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UNITED CEREBRAL PALSY ASSOCIATIONS OF NEW YORK STATE, INC.,

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MARIO CUOMO, as Governor of the State of New York; ELIN HOWE, as Commissioner of the New York State Office of Mental Retardation and Developmental Disabilities; LORNA McBARNETTE, as Acting Commissioner of the New York State Department of Health; GREGORY M. KALADJIAN, as Acting Commissioner of the New York State Department of Social Services; PATRICK BULGARO, as Director of the New York State Division of the Budget,

Respondents.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

PETITION FOR WRIT OF CERTIORARI

Petitioner United Cerebral Palsy Associations of New York State, Inc. respectfully requests that a writ of certiorari issue to review the judgment and opinion of the United States Court of

Appeals for the Second Circuit, entered in the above-entitled proceeding on June 11, 1992.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Second Circuit is reported at __ F.2d __ (2d Cir., 1992), 1992 WL 126719 (2d Cir., 1992), and is reprinted at Appendix A, p. 1, infra.

The opinion of the United States District Court for the Northern District of New York is reported at 783 F.Supp. 43 (N.D.N.Y., 1992)(Cholakis, J.) and is reprinted at Appendix B, p.1, infra.

JURISDICTION

Petitioners brought this action in the United States District Court for the Northern District of New York on December 19, 1991, seeking declaratory, injunctive, and other relief pursuant to Title XIX of the Social Security Act, 42 U.S.C. Section 1396, et seq., commonly known as the Medicaid Act, and under 42 U.S.C. Section 1983. In a memorandum and order dated February 3, 1992, the Hon. Con G. Cholakis, U.S.D.J., denied the petitioner's motion for a preliminary injunction.

On Petitioner's appeal, the United States Court of Appeals for the Second Circuit entered a judgment affirming the order of the District Court, in an opinion dated June 11, 1992.

The jurisdiction of the United States Supreme Court to review the judgment of the Court of Appeals is invoked pursuant to 28 U.S.C. Section 1254(1).

STATUTES AND REGULATIONS

42 U.S.C. Section 1396a(a)(13)(A):

A State plan for medical assistance must

(13) provide --

(A) for payment . . . of the hospital, skilled nursing facility, and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State . . .) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and federal laws, regulations and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality....

42 C.F.R. Section 430.10. The State Plan.

The State Plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX,

the regulations in this Chapter IV, and other applicable issuances of the department. The State plan contains all information necessary for HCFA to determine whether the plan can be approved to serve as a basis for federal financial participation (FFP) in the State program.

42 C.F.R. Section 430.12 (c). Plan amendments.

(1) The plan must provide that it will be amended whenever necessary to reflect --

(i) Changes in Federal law, regulations, policy interpretations, or court decisions; or

(ii) Material changes in State law, organization, or policy, or in the State's operation of the Medicaid program.

42 C.F.R. Section 447.45(d). Timely processing of claims.

(1) The Medicaid agency must require providers to submit all claims no later than 12 months from the date of service.

(2) The agency must pay 90 percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 30 days of the date of receipt.

(3) The agency must pay 99 percent of all clean claims from practitioners,

who are in individual or group practice or who practice in shared health facilities within 90 days of the date of receipt.

(4) The agency must pay all other claims within 12 months of the date of receipt. . . .

42 C.F.R. Section 447.253(a), (b). Other requirements.

(a) State assurances. In order to receive HCFA approval of a State plan change in payment methods and standards, the Medicaid agency must make assurances satisfactory to HCFA that the requirements set forth in paragraphs (b) through (g) of this section are being met, must submit the related information required by Section 447.255 of this subpart, and must comply with all other requirements of this subpart.

(b) Findings. Whenever the Medicaid agency makes a change in its methods and standards, but not less often than annually, the agency must make the following findings:

(1) Payment rates. (i) The Medicaid agency pays for inpatient hospital services and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards . . . .

STATEMENT OF THE CASE

THE MEDICAID PROGRAM AND THE STATE OF NEW YORK'S PERMANENT PAYMENT DELAY.

The Medicaid program, established under Title XIX of the Social Security Act, 42 U.S.C. Sections 1396, et seq., establishes a joint federal-state cost sharing system to provide necessary medical services to indigent persons, including families with dependent children, and aged, blind and disabled individuals who would otherwise be unable to afford medical care. New York State has chosen to participate in the program, and has developed a State Plan by which it administers the Medicaid program. New York receives federal reimbursement in the amount of 50% of payments made to participating individual and institutional health care providers, including

governmental, private proprietary and voluntary not-for-profit providers of services. New York State reimburses nongovernmental health care providers through the Medicaid Management Information System (MMIS); providers operated by the State of New York itself receive payments directly from the State.

Pursuant to the Boren Amendment to the Medicaid Act, 42 U.S.C. Section 1396a(a)(13)(A), a state is required to submit its State Plan to the Secretary of the United States Department of Health and Human Services, providing findings and assurances that the plan provides for payment for Medicaid services based on rates that are reasonable and adequate to meet the costs incurred by efficiently and economically operated facilities which provide care that conforms with applicable

laws, regulations, and quality and safety standards.

Regulations issued by the Secretary provide that a state Medicaid agency must make specific findings and provide assurances to the Secretary that any change in its "payment methods and standards" conforms to the requirements of the Medicaid Act, including new findings and assurances that any change in rate of reimbursement to providers of services continues to provide a reasonable and adequate reimbursement rate. Further, regulations require a state to amend its State Plan to reflect material changes in the state's operation of the Medicaid program.

Therefore, if a state makes changes in its methods and standards of

determining the rate of Medicaid reimbursement, and fails to make the specific findings or assurances prescribed in federal law, then the changes proposed are null and void. Similarly, if a state makes material changes in its' operation of the Medicaid program, but fails to promptly amend its State Plan to reflect those changes, then those changes are also null and void.

In August, 1991, the New York State Department of Social Services announced the institution of a delay in payment of Medicaid checks by one week, to be gradually phased in by delaying the payments one day per week. Under the delay as implemented in the state's announcement, no Medicaid reimbursement check would be received the week of December 30, 1991 - January 3, 1992. The

Department of Social Services later amended the plan to provide that the week of no reimbursement check would be February 3-7, 1992. Medicaid reimbursement was withheld pursuant to the announced schedule, despite services having been rendered pursuant to applicable federal and state laws, regulations, and quality and safety standards. The stated reason for the payment lag was "to address the State's critical financial situation in the current year."

A second one-week delay was instituted in February, 1992, whereby the reimbursement schedule was again extended, resulting in no Medicaid reimbursement the week of March 16-20, 1992.

Respondents did not make any findings and assurances required by the Medicaid law and regulations to be made prior to implementing the change in the methods and standards of determining Medicaid reimbursement Moreover, the respondents did not amend the State Plan, despite a change in the state's operation of the Medicaid program.

THE EFFECT OF THE PERMANENT PAYMENT DELAY ON PETITIONER.

The evidence presented to the District Court demonstrated that petitioner United Cerebral Palsy Associations of New York State, Inc. is a not-for-profit corporation providing a wide array of services to mentally retarded and developmentally disabled individuals. Petitioner operates programs and services for over 1000 individuals in

New York City and upstate New York. Together with its 25 affiliates and divisions in New York State, services are provided to over 30,000 disabled adults and children, and their families.

Over 97% of petitioner's revenue is derived from Medicaid payments for its intermediate care facilities for the mentally retarded/developmentally disabled. The permanent withholding of two-weeks' Medicaid reimbursement has caused petitioner to fail to meet its legal and contractual obligations to staff, vendors, business relations and to the individuals with disabilities served by the agency.

For fiscal year 1992, petitioner provided 52 weeks of services, yet was paid for only 50 weeks of services.

Evidence presented to the District Court demonstrated that the two weeks' delay in payments results in a loss of approximately $1.5 million to petitioner, and a total loss of approximately $6 million to the petitioner's local affiliates and divisions. The cost of operating petitioner's residential program exceeds the weekly reimbursement; thus, loss of two week's cash has severely affected petitioner's ability to continue to provide the care and treatment mandated by law to the residents of its programs. The failure to pay vendors has resulted in the loss of some of the very few vendors willing to provide materials and services to agencies serving developmentally disabled individuals.

Petitioner has been forced to spend considerable time searching for financing

to cover the loss of cash occasioned by the permanent withholding. There are no additional hard assets that could serve as collateral for loans. Thus, petitioner has been faced, and continues to be faced with making cuts in programs and services. Many of the services provided, including therapy services, health services, and other services and treatments to ensure the preservation of the health, safety and welfare of the residents, are required to be provided by federal and state Medicaid statutes and regulations. The permanent withholding has required, and will continue to require, petitioner to lay off therapists, clinicians, and other employees, risking the reduction in the quality and quantity of programs and services to below that required by governing laws.

DISTRICT COURT PROCEEDINGS

Petitioners filed their complaint on December 19, 1991, seeking declaratory, injunctive, and other relief against respondents.[1] On January 10, 1992, petitioners sought a temporary restraining order against the institution of the permanent delay in reimbursement, arguing that the delay constituted a violation of the Boren Amendment to the Medicaid Act, 42 U.S.C. Section 1396a(a)(13)(A), and its implementing regulations, 42 C.F.R. Section 447.253 (a), (b). Petitioners argued that the one week withholding[2] resulted in a reduction in the rate of

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[1]Petitioner also sought relief against the Secretary of the United States Department of Health and Human Services. That claim was dismissed by stipulation filed February 3, 1992.

[2]At the time that the motion was filed, the second week of payment lag had not yet been announced. Both the District Court and the Court of Appeals considered the issues as applying to both weeks of payment lag.

payment, to a rate below that previously determined to be reasonable and adequate. Petitioners also argued that the change in the timeliness of payments constituted a change in "payment methods and standards" for which the state was required to make findings and assurances, and seek approval of the Secretary of health and Human Services, pursuant to 42 C.F.R. Section 430.12 (c).[3]

The District Court denied the petitioner's request for a temporary restraining order on January 10, 1992.

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[3]Petitioner also sought relief under the Due Process and Equal Protection Clauses of the Fifth and Fourteenth Amendments to the United States Constitution, and the New York Constitution. Petitioner claimed that the permanent payment lag was a taking of property without just compensation, a deprivation of property without due process of law, and a denial of equal protection under the law, because state operated providers were not subject to the payment lag. Petitioner also brought pendent state claims under the New York State Administrative Procedure Act.

On January 31, 1992, the District Court denied petitioner's motion for a preliminary injunction. In a written memorandum decision and order that followed on February 3, 1992, the District Court found that petitioner did not demonstrate likelihood of success on the merits of the claim that the Medicaid payment lag was a change in methods and standards of payment implicating the requirement of making "findings" and "assurances" under the Boren Amendment, 42 U.S.C. Section 1396a(a)(13)(A) and 42 C.F.R. Section 447.253 (a) and (b).[4] The District Court also found that the permanent payment lag did not violate the statutes and regulations requiring an

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[4]St. Luke's-Roosevelt Hospital Center was permitted to intervene by order dated January 31, 1992. Intervenor St. Luke's raised issues similar to those raised by petitioner.

amendment to the State Plan.[5] (Appendix B).

APPELLATE COURT PROCEEDINGS

On February 7, 1992, Intervenor St Luke's-Roosevelt Hospital Center filed a Notice of Appeal with the District Court. On February 21, 1992, petitioner filed its Notice of Appeal with the District Court. Oral argument was heard on March 31, 1992.

On June 11, 1992, the appellate panel affirmed the order of the District Court denying petitioner's motion for a preliminary injunction, and entered a judgment to that effect (Appendix A). The appellate panel based its decision on the

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[5]The District Court also denied petitioner's claims under the Fifth and Fourteenth Amendments to the United States Constitution, and denied petitioner's claims alleging violation of state laws as barred by the Eleventh Amendment to the United States Constitution.

language of the Boren Amendment, finding that, while the statute requires that rates of payment be established as adequate, there is no requirement as to the date of payment. The appellate panel, following Illinois Council on Long Term Care v. Bradley, et al., 957 F.2d 305 (7th Cir. 1992), cert filed ___ U.S. ___, Dkt. 91-1679[6], found that, while petitioner's argument, that the delay constituted a change in the rate of payment because of the time value of money, had validity, the Boren Amendment and its implementing regulations allow for such diminutions, so long as payments are made within 12 months of date of receipt (42 C.F.R. Section 447.45(d)(4))(id. at 4-5). The panel also found that the payment delay was not a change in "payment methods and standards"

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[6]According the Office of the Clerk of the Supreme Court, Illinois Council is scheduled to appear on the Court's conference calendar on September 28, 1992.

for which the state was required to make findings and assurances pursuant to 42 C.F.R. Section 447.253 (id. at 5), and did not find that the delay constituted a "material change in State law, . . . or in the State's operation of the Medicaid program", requiring an amendment to the State Plan pursuant to 42 C.F.R. Section 430.12(c). Finally, the panel determined that the implementing regulations of the Boren Amendment and the Medicaid Act only spoke of setting rates, not time of payment. Therefore, the panel decided that petitioners did not have a likelihood of success on the merits and entered judgment affirming the order of the District Court.[7]

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[7]The appellate panel also affirmed the District Court's dismissal of the constitutional claims. (id. at 6-7).

REASONS FOR GRANTING CERTIORARI

I.

THE DECISION OF THE COURT OF APPEALS, THAT A STATE'S PERMANENT LAG IN PAYMENT OF MEDICAID REIMBURSEMENT IS NOT A REDUCTION IN THE RATE OF REIMBURSEMENT, IS CONTRARY TO THIS COURT'S INSISTENCE ON A STATE'S STRICT COMPLIANCE WITH THE BOREN AMENDMENT'S "FUNDAMENTAL OBLIGATION" TO REIMBURSE PROVIDERS ACCORDING TO REASONABLE RATES, AS WELL AS THE EXPRESS PROVISIONS OF THE BOREN AMENDMENT ITSELF.

In fiscal year 1992, the State of New York instituted a permanent Medicaid reimbursement payment lag, extending the period in which payment was to be made from 14 days to 28 days. In doing so, the state withheld two weeks of Medicaid reimbursement. By only making 50 payments for 52 weeks of service, the State of New York effectively reduced Medicaid reimbursement to providers for fiscal year 1992 by four percent. As a result, petitioner and its' New York State affiliates and divisions lost $6 million

in reimbursement for services already rendered, money they will not see until 28 days after they go out of business.

The Court of Appeals held that, under the Boren Amendment to the Medicaid Act, 42 U.S.C. Section 1396a(a)(13)(A), and its implementing regulations, a state could, for budgetary purposes, institute a permanent lag in payments for budgetary reasons, and that, during the period in which the lag was being implemented, the state could withhold payments to providers. The appellate panel found that the Boren Amendment itself did not contain, or even imply, any time limit whatsoever on a state's payment of Medicaid reimbursement to health care providers. Indeed, the only time limit found by the court was the 12 month limit imposed by 42 C.F.R. Section 447.45(d). By holding that the Boren Amendment

requires only the establishment of rates, but not timely payment of reimbursement according to those rates, the appellate panel relegated the detailed substantive and procedural requirements of the statute and implementing regulations to "mere surplusage," rendering those requirements "a dead letter."

A. The Decision Of The Court, That The State May Delay Payment For Up To One Year Without Making "Findings" And "Assurances" Is Contrary To This Court's Interpretation Of The Boren Amendment.

By its terms, the Boren Amendment and its implementing regulations impose procedural and substantive requirements on states that must be observed prior to any action by the state which would alter the payment policy or impose significant payment changes on providers of services under the Medicaid program. Under the Boren Amendment, a state must

> make "findings" which identify and determine (1) efficiently and economically operated hospitals; (2) the costs that must be incurred by such hospitals; and (3) payment rates which are reasonable and adequate to meet the reasonable costs of the state's efficiently and economically operated hospitals.

Pinnacle Nursing Home v., Axelrod, 928 F.2d 1306, 1314 (2d Cir. 1991). This Court and other courts have strictly held states to those requirements.

In Wilder v. Virginia Hospital Association, 496 U.S. 490, 110 S.Ct. 2510, 110 L.Ed. 2d 455 (1990), this Court held that Congress, in enacting the Boren Amendment, created a substantive federal right, enforceable by providers, to the adoption of reasonable and adequate reimbursement rates, and that it was a "fundamental obligation" of a state to pay providers based on reasonable and adequate rates. 110 S.Ct. at 2513, 2520. The Court

held that "a State must reimburse providers according to rates" it has established, and not to merely set rates. Id. at 2516. See also, Pinnacle, Id. at 1315. (In determining that New York State violated the Boren Amendment vis a vis nursing home reimbursement, the court found that New York State's "findings" were "little more than a policy decision.")

The appellate panel in the case at issue, however, found that the Boren Amendment required only that the state establish a rate that is reasonable and adequate, and not that the state is required to make prompt payments based on that rate. (Appendix A, pp. 8-11). The appellate panel did not find any time limit for payment whatsoever imposed by the Boren Amendment. Indeed, the only requirement that the appellate panel would

impose on states is to make payments, based on reasonable and adequate rates, within twelve months of submission of bills. Id. Thus, according to the Court of Appeals, a state would be free to establish rates that are "reasonable and adequate, etc.", and then wait an entire year after submission of bills before paying the providers for services already rendered. Although the appellate panel recognized that a delay in payment, even for two weeks, did result in a loss of money due to the time value of money, it did not consider the resulting loss of funding, even for a full year, to be a de facto reduction in the rate of payment, requiring findings and assurances under the Boren Amendment. That determination flies in the face of the intent of Congress that the Boren Amendment was "not intended to encourage arbitrary reductions in payment that would adversely affect the

quality of care." Wilder, Id. at 2520, citing S.Rep. No. 96-471, at 29. The permanent payment lag, instituted without the state making findings and assurances as required by the Boren Amendment, is precisely the type of arbitrary reduction in payments to which the Boren Amendment was addressing, and which this Court condemned in Wilder.

Courts have recognized that permanently delaying payment is a reduction in the amount of that payment. In Association of Surrogates & Supreme Court Reporters v. New York, 940 F.2d 766 (2d Cir. 1991), cert. denied, __ U.S. __, 112 S.Ct. 936 (1992), the Court of Appeals found that a two-week pay lag for state employees had "the effect of withholding (a portion) of each employee's expected wages over a period of (time) . . . and postponing their payment indefinitely."

Id. at 772. See also, Association of Surrogates and Supreme Court Reporters v. New York, __ N.Y. 2d __, 1992 WL 5676 (January 16, 1992) (in rejecting a pay lag, the New York Court of Appeals determined that "to withhold earnings to be paid at some future date either upon the employee's retirement or payable to his or her estate is simply taking the employee's wage to be used by the public employer as it sees fit.")[8]

The principle recognized by the U.S. Court of Appeals, and the New York Court of Appeals, in the Association of Supreme

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[8]The Appellate Panel below dismissed the Association of Supreme Court Reporters cases because the legal basis for those rulings were findings that the employees at issue had contractual rights which were impaired, in violation of the contract clause, Article I, Section 10, clause 1 of the United States Constitution. (Appendix A, page. 13-14) However, the discussion of the injury to the employees, and the recognition by the courts in the Association cases, that delayed payment is reduction in payment, applies to the instant case regardless of whether or not the contract clause governs.

Court Reporters cases, applies with equal force to the matter at hand. The rates approved as "reasonable and adequate" pursuant to the Boren Amendment are the rates that must, in fact, be paid. In effecting the Medicaid reimbursement lag, the state withheld two weeks of reimbursement, paying providers for only 50 weeks in fiscal year 1992. A deliberate decision to withhold payment based on those rates is a reduction of those rates, for which new findings and assurances must be made. See also, St. Tammany Parish Hosp. Dist. v. Dept of Health & Human Resources, 677 F.Supp. 455 (E.D.La. 1988) (Delay in making Medicaid payments constituted a de facto reduction in payment rate implicating the Boren Amendment procedures); Ohio State Pharmaceutical Assn v. Creasy, 587 F.Supp. 698, 706 (S.D. Ohio 1989) (Delay in payment of Medicaid reimbursement does not

exempt state from requirements of the Boren Amendment.)

No findings and assurances were made in the case at hand, in spite in the reduction in payment to providers of four percent for fiscal year 1992. The Court of Appeals, in determining that no findings and assurances were required, ignored the clear requirements of the Boren Amendment. The panel's decision invites other states to treat the Boren Amendment as a charade, making detailed findings that a Medicaid reimbursement rate is reasonable and adequate, and then refusing to reimburse providers for up to one year, as long as that "rate" set on paper remains.

In Wilder, this Court evidenced a concern that the Boren Amendment be interpreted in such a manner as to render

it "a dead letter." Id. at 2520. The Court of Appeals' decision allowing states to effectuate a reduction in the Medicaid reimbursement rate by withholding reimbursement for up to one year, without making the findings and assurances that the resulting rate continues to be reasonable and adequate, eviscerates the procedural requirements of the Boren Amendment in a fashion contradictory to the intent of this Court in Wilder. The appellate panel's judgment must therefore be reversed.

B. The Court Of Appeals Erred In Determining That The Permanent Medicaid Reimbursement Lag Was Not A Material Change In Policy, Or A Change In the Method Of Operating The Medicaid Program, Mandating An Amendment To The State Plan For Medicaid.

Even if the permanent lag in payments to providers, resulting in a four percent reduction in reimbursement for fiscal year

1992, is not a change in the rate of payment, it is certainly a change in state policy, and in the state's operation of the Medicaid program, requiring an amendment to the state plan for Medicaid pursuant to 42 C.F.R. Section 447.45(d). Indeed, the net effect of the state's new policy regarding Medicaid reimbursement will fundamentally affect how Medicaid services will be provided.

Evidence provided to the District Court demonstrated that New York State provides Medicaid through a dual system; the state itself provides services, as does a network of both profit and not-for-profit voluntary providers. The effect of the permanent lag in payments (which applies only to the nongovernmental sector) was to withhold four percent ($6 million) from petitioner and its New York State affiliates. In total, the State of

New York withheld over $800 million from the network of private providers.

Petitioner and its affiliates were, and continue to be, required under federal and state laws, regulations, and quality and safety standards, to provide a wide array of services to the mentally retarded and developmentally disabled individuals residing in the intermediate care facilities operated by petitioner and its affiliates. The arbitrary reduction in payments for services already rendered required petitioner to commit resources to obtaining additional financing, and to reduce both the quality and quantity of staff, to continue to fulfill legal requirements for services to its residents.

The decision of the Court of Appeals would permit a state to withhold

reimbursement for services legally required to be rendered for up to one year. Such an action would undoubtedly put petitioner, and many other voluntary agencies, out of business[9]. This reduction in the system of voluntary providers is certainly contrary to the purposes of the Medicaid program as enunciated by Congress, to provide necessary medical care to poor, aged and/or disabled individuals.

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[9]Contrary to the opinion of the Court of Appeals, evidence presented to the District Court demonstrated that the payment lag does not apply to all Medicaid providers, only those paid through the New York State MMIS program. The state itself is the largest provider of Medicaid services; since it does not itself participate in the MMIS program, the programs operated by the state itself are exempted from the Medicaid reimbursement lag. Although petitioner challenged this disparity in the lower courts, the District Court, and the Court of Appeals, rejected petitioner's arguments based on the equal protection clauses of the Fifth and Fourteenth Amendments to the U.S. Constitution.

II.

THE COURT OF APPEALS' DECISION IS CONTRARY TO THE EXPRESS INTENTION OF CONGRESS AND OF THE EXECUTIVE BRANCH, THAT FAILURE TO MAKE PROMPT PAYMENT OF MEDICAID REIMBURSEMENT INVOKES THE REQUIREMENTS OF THE BOREN AMENDMENT.

Both the United States Congress and the U.S. Department of Health and Human Services have indicated that adjustments to the payment schedule for Medicaid reimbursement require findings and assurances under the Boren Amendment. In refusing to recognize the positions of both the Congress and the Executive Branch, the appellate panel conflicts with the clear position of the other two branches of the federal government.

Petitioner's argument is consistent with the stated position of the Executive Branch. The appellate panel erroneously refused to recognize that, since 1987,

the United States Department of Health and Human Services has required all changes in payment methods and standards to be subject to submission of findings and assurances. Previously, the Department required only significant changes to be subject to the requirement of findings and assurances. Responding to comments that the extension of findings and assurances requirement to all changes would be burdensome, the Department wrote that, even if a state made minor changes that did not involve the computation of the rate, there still must be a submission of findings and assurances. In that instance, however, a state need not make new findings, but may instead provide a statement that the existing findings and

assurances still applied. See 52 Fed. Reg. 28142 (July 28, 1987.)[10]

The Medicaid Act cannot be construed to allow hospitals and nursing homes to be denied payment for up to one year, while imposing a strict time limit for payments to practitioners (who are unprotected by the Boren Amendment) under 42 C.F.R. Section 447.45(d). The only consistent reading of the statute and regulations would be to determine that a strict statutory or regulatory limit for payment to hospitals and nursing homes would be

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[10]The Department wrote:

> The requirement to submit assurances and related supporting information for all plan changes should not be burdensome on the States. (A) plan amendment that makes only procedural changes to the State's methods and standards, and that does not revise the computation of the rate payable to the facility, would not require the state to prepare and submit revised data in support of its assurances. Under these circumstances, the resubmittal of applicable data prepared by the State for its most recently approved State plan would be acceptable, as would an assurance that the previously submitted data remains valid.

unnecessary, given the requirements of the Boren Amendment.

This is confirmed by the decision and the Congressional response to Chicago Osteopathic Medical Ctrs. v. Duffy, CCH Medicare and Medicaid Guide Para. 38,395, 1989 WL 135234 (N.D.Ill. 1989) ("COMC"). In COMC, the state had a statutory waiver of the Boren Amendment requirements for negotiating a rate with hospitals, pursuant to 42 U.S.C. Section 1396n. The state then delayed payment based on that negotiated rate. The court noted that, in the Boren Amendment context,

> providers and recipients of Medicaid faced injury as a result of unilateral rate decisions on the part of the State. . . . As a result, providers were forced to accept less money than they had reasonably budgeted for costs incurred, in violation of (the Boren Amendment). Accordingly, these actions adversely affected the goals that section 1396a(a)(13)(A) seek to promote -- i.e., affording the providers the ability to meet reasonable costs and

> thereby insuring that recipients receive continued access to needed services.

COMC, at *2. Clearly, the court determined that the Boren Amendment applied to delays in payment, and that prompt payment was part and parcel of the "reasonable and adequate" rate. However, the court then distinguished the circumstances of the Boren Amendment context with those of the waiver of the statute's requirements, finding that, in the context of the waiver based on a negotiated rate, there was no requirement for prompt payment.

Congress then, in response to COMC, amended the negotiated rate waiver exception to the Boren Amendment and required, when a waiver of the Boren Amendment exists, payment within 30 days

of receipt of bills. 42 U.S.C. Section 1396n(b)(4).

Therefore, when a waiver of the Boren Amendment's requirements exists, payment must be made within 30 days. It defies belief that, when the requirements of the Boren Amendment do exist, hospitals and nursing homes are not entitled to similar prompt payment. Congress plainly understood that the requirements of the Boren Amendment encompassed the time of payment, and that delays in payment implicated the requirement of findings and assurances, that the resulting rate still remained reasonable and adequate.

Curiously, the appellate panel's decision in the instant case ignored the clear intent of Congress following COMC, that prompt payment is part and parcel of the reasonable and adequate Medicaid

reimbursement rate. There is no discussion of COMC or of the congressional response, or of the statements by the U.S.Department of Health and Human Services mandating compliance with the Boren Amendment. The appellate panel's decision is contrary to the positions of the Congress and of the Executive Branch, and must therefore be reversed.

III.

THE COURT OF APPEALS' DECISION PERMITTING STATES TO REDUCE MEDICAID REIMBURSEMENT TO A LEVEL BELOW THAT PREVIOUSLY DETERMINED TO BE REASONABLE AND ADEQUATE, SOLELY FOR BUDGETARY PURPOSES, WITHOUT FIRST SUBMITTING FINDINGS AND ASSURANCES UNDER THE BOREN AMENDMENT, IS CONTRARY TO THE INTENT OF CONGRESS AND TO CONSISTENT FEDERAL COURT DECISIONS THROUGHOUT THE NATION.

In enacting the Boren Amendment, Congress expressly stated that states could not implement a Medicaid reimbursement system based on rates

developed "solely on the basis of budgetary appropriations." H. Conf. Rep. 1497, 96th Cong. 2d Sess. 154 (1980). Numerous cases have found that payment reductions for budgetary reasons are not immune from the requirements of the Boren Amendment. See, e.g. AMISUB (PSL), Inc. v. Colorado Dept. of Social Serv., 879 F.2d 789, 801 (10th Cir. 1989) cert. denied, 110 S.Ct. 3212 (1990)("If a state could evade the requirements of the [Medicaid] Act simply by failing to appropriate sufficient funds to meet them, it could rewrite the congressionally imposed standards at will."); Wisconsin Hosp. Assn. v. Reivitz, 733 F.2d 1226, 1235 (7th Cir. 1984) ("budgetary concerns [cannot] excuse a failure to conform to the Federal 'reasonable and adequate' standard."); Illinois Hosp. Assn. v. Illinois Dept. of Public Aid, 579 F.Supp. 360 (N.D.Ill. 1983) (Multicare Medical

Ctr. v. State of Wash., 768 F.Supp. 1349, 1393 (D. Wash. 1991); Nebraska Health Care Assn. v. Dunning, 578 F.Supp. 543 (D. Neb. 1983) affd. in part 778 F.2d 1291 (8th Cir. 1986) cert. denied 479 U.S. 1063 (1987); Kansas Health Care Assn. v. Kansas Dept of Social Serv., 754 F.Supp. 1502 (D. Kan. 1990).

States that have attempted to reduce Medicaid reimbursement for budgetary purposes have consistently been required to make findings and assurances that the resulting reimbursement rates continued to be reasonable and adequate. See, e.g., AMISUB (PSL), Id., Nebraska Health Care Assn. v. Dunning, Id. In the instant case, it is undisputed that the state delayed payment of Medicaid reimbursement solely for budgetary purposes. The decision of the Court of Appeals would permit the state to continue to delay such

payment for a full year, without implicating the Boren Amendment. That decision is contrary to consistent decisions of federal courts throughout the nation, and must be reversed.

CONCLUSION

For all he foregoing reasons, petitioner respectfully requests that this Court grant this petition for a writ of certiorari, and review and reverse the decision and judgment of the United States Court of Appeals for the Second Circuit.

Respectfully submitted,

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APPENDICES

United Cerebral Palsy Associations of New York State, Inc., et al., v. Mario Cuomo, etc. et al., ___ F.2d ___ (2d Cir., 1992), 1992 WL 126719 (2d Cir. 1992) A1

United Cerebral Palsy Associations of New York State, Inc., et al., v. Mario Cuomo, etc. et al., 783 F.Supp. 43 (N.D.N.Y.,1992) B1

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

No. 1344 - August Term 1991
(Argued: March 31, 1992
Decided: June 11, 1992)
Docket Nos. 92-7195, 92-7235

UNITED CEREBRAL PALSY ASSOCIATIONS OF NEW YORK STATE, INC.,

Plaintiff-Appellant,

and THE ST. LUKE'S-ROOSEVELT HOSPITAL CENTER,

Intervenor-Plaintiff-Appellant,

v.

MARIO CUOMO, as Governor of the State of New York; ELIN HOWE, as Commissioner of the New York State Office of Mental Retardation and Developmental Disabilities; LORNA McBARNETTE, as Acting Commissioner of the New York State Department of Health; GREGORY M. KALADJIAN, as Acting Commissioner of the New York State Department of Social Services; PATRICK BULGARO, as Director of the New York State Division of the Budget,
Defendants-Appellees.

Before:

MINER, McLAUGHLIN, Circuit Judges,
and OWEN, District Judge.*

*The Honorable Richard Owen, Senior District Court Judge of the Southern

District of New York, sitting by designation.

Appeal from order of the United States District Court for the Northern District of New York, Con. G. Cholakis, J., denying plaintiff's and intervenor-plaintiff's motion for a preliminary injunction.

Affirmed.

STEVEN H. MOSENSON, New York, New York (Glenn M. Rickles, General Counsel, United Cerebral Palsy Assoc. of N.Y.S. Inc., New York, NY, of counsel), for Plaintiff-Appellant.

EDWARD S. KORNREICH, New York, New York (Stephen P. Kramer, Stephen A. Wieder, Proskauer Rose Goetz & Mendelsohn, New York, NY, of counsel), for Intervenor-

Plaintiff-Appellant.

JUDITH I. RATNER, Assistant Attorney General of the State of New York, Albany, New York (Robert Abrams, Attorney General, Peter H. Schiff, Deputy Solicitor General, Peter G. Crary, Assistant Attorney General, Albany, NY of counsel) for Defendants- Appellees.

Richard A. Levy, New York, New York (Mitra Behroozi, Fanette Pollack, Eisner, Levy, Pollack & Ranter, New York, NY, of counsel) for Amicus Curiae, Local 1199, Drug, Hospital & Health Care Employees Union.

OWEN, District Judge:

Plaintiff United Cerebral Palsy Associations of New York ("UCPA") and

Intervenor-plaintiff The St. Lukes's-Roosevelt Hospital Center appeal from an interlocutory order of the United States District Court for the Northern District of New York, (Con. G. Cholakis, Judge) denying their motion for a preliminary injunction. They seek to preliminarily enjoin New York State from implementing a two week delay in reimbursement of Medicaid payments from fourteen to twenty eight days on the ground that the delay violates the Medicaid Act, 42 U.S.C. Section 1396 et seq., specifically the Boren Amendment to the Medicaid Act, Section 1396a(a)(13)(A), and the regulations promulgated thereunder, specifically, 42 C.F.R. Section 447.253(a) and (b), and the due process, equal protection, and taking clauses of the United States Constitution. Concluding that on this record appellants have failed to demonstrate either a likelihood of

success on the merits or the existence of sufficiently serious questions going to the merits, we affirm the order of the court below.

UCPA is a not-for-profit corporation which provides health care services to mentally retarded and developmentally disabled people. UCPA operates approximately 70 community residences for individuals who cannot live independently, each of which is covered by Medicaid provider agreement signed by UCPA and New York State. Over 97% of UCPA's revenue is derived from Medicaid payments for those intermediate care facilities. St. Luke's-Roosevelt is a non-governmental, not-for-profit hospital which receives weekly Medicaid reimbursement checks of approximately $3.4 million.

New York State participates in the

Medicaid program, a joint federal and state cost-sharing system that pays health care providers for medical services provided to those who cannot afford to pay for such services themselves. In the past, New York has reimbursed providers such as appellants within 14 days of receipt of claims. In August 1991, New York State as part of an overall effort to improve its own troubled fiscal situation, announced that it would begin to send out Medicaid reimbursement checks within 28 days of receipt of claims.[1] This delay was implemented gradually over a five month period, concluding in March 1992, the last week of the fiscal year. The rate at which health care providers are reimbursed was not changed and providers are still paid for all services rendered.

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[1]The State has exempted from the delay all "financially distressed" hospitals as defined by New York State Public Health Law, N.Y. Pub. Health L. Section 2807-c (14-c).

Only the date on which reimbursement payments are sent was altered. Appellants contend that this two week delay in reimbursement violates the Medicaid Act, the regulations promulgated thereunder, and the Federal Constitution.

The Medicaid program, established in Title XIX of the Social Security Act, is a joint federal and state system. State participation in the program is optional, but a state that elects to participate must comply with federal statutory requirements. A state participating in the program is required to submit to the Secretary of Health and Human Services a "plan for medical assistance," 42 U.S.C. Section 1396, that establishes a scheme for reimbursing health care providers for the medical services provided to indigent patients. The Boren Amendment requires that a State plan for medical assistance

must,

> (13) provide -
>
> (A) for payment...of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State...) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities....

42 U.S.C. Section 1396a9a)(13)(A).

Thus, the Boren Amendment requires that the rates of payment established by the State be adequate; there is no requirement as to the date of payment. On its face, the statute does not impose time limits or refer to timeliness in any way. See Illinois Council on Long Term Care, et al. v. Bradley, et al., 957 F.2d 305, 308 (7th Cir. 1992). The regulations implementing the Boren Amendment, 42

C.F.R. Section 447.250 et seq., refer only to adequate rate setting and say nothing about the date on which payment must be made. Where the regulations do speak of time requirements, 42 C.F.R. Section 447.45(d)(4), that provision requires that the Medicaid agency pay all claims within 12 months of the date of receipt. New York's 28 day repayment scheme is obviously within this.

Appellants argue, however, that any delay in payment constitutes a rate change because a dollar paid today is worth more than a dollar paid two weeks from today. While appellants' claim may have some merit with regard to the time value of money, the Boren Amendment and its implementing regulations allow for such a diminution, so long as payments are made within 12 months, and accordingly such a lag does not constitute a rate change.

See Illinois Council, 957 F.2d at 308. An example provided by appellees is instructive: "when a purchase is made on credit, an individual generally has 30 days to make payment. The price of the goods or services, the payment rate, does not change regardless of whether one pays the bill at the beginning of the 30 days or at the end of the 30 days. The date of payment may vary within the 30 day period, but the payment rate remains the same." Appellees' Brief at 9. Similarly, here, the regulations permit the State to reimburse claims within 12 months of receipt; so long as the State meets this deadline, the amount - the rate - paid remains constant. Under appellants' theory, any delay would constitute a change in rate forcing the Medicaid agency to go back to the drawing board to seek approval whenever payments were delayed, even if for one day. Neither the statute

nor the regulations require such action.

Second, appellants argue that New York's change in the date of payment constitutes a change in "payment methods and standards" and therefore the State must make findings and assurances that its rates are reasonable and adequate to meet the costs of the facilities, pursuant to 42 C.F.R. Section 447.253.[2] The section under which this provision falls is entitled **"PAYMENT RATES"** and addresses methods and standards for rate setting.

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[2]42 C.F.R. Section 447.253 provides:

(a) State assurances. In order to receive HCFA approval of a State plan change in payment methods and standards, the Medicaid agency must make assurances satisfactory to HCFA that the requirements set forth in paragraphs (b) through (g) of this section are being met,...

(b) Findings. Whenever the Medicaid agency makes a change in its methods and standards,... the agency must make the following findings:

(1) Payment rates. (i) The Medicaid agency pays for...services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers...

See Illinois Council, 957 F.2d at 309; 42 C.F.R. Section 447.252(b) ("The plan must specify comprehensively the methods and standards used by the agency to set payment rates...")(emphasis added); Section 447.253(f) ("The Medicaid agency must provide that it has complied with the public notice requirements...when it is proposing significant changes to its methods or standards for setting payment rates...")(emphasis added); Section 447.253(g) ("The Medicaid agency must pay...using rates determined in accordance with methods and standards specified in an approved State plan")(emphasis added). Because, as discussed above, we find that a change in the date of payment does not equal a change in the rate of payment, New York has not altered its methods and standards for setting rates, and thus the State had no obligation to make assurances or findings under this section.

Neither does the delay constitute a "material change[] in State law,...or in the State's operation of the Medicaid program" 42 C.F.R. Section 430.12(c) and thus, New York had no obligation to amend its State plan. The State plan, with its established rate of reimbursement, is unchanged and, having previously received approval for the plan from the Secretary, New York is in compliance with the statute and regulations.

Appellants rely heavily on Association of Surrogates and Supreme Court Reporters v. New York, 940 F.2d 766 (2d Cir. 1991), cert. denied, ___U.S. ___, 112 S.Ct. 936 (U.S. 1992), in which the Court, on contract grounds, struck down an extensive lag in portions of salary payments to New York State employees which had been theretofore established by a collective bargaining agreement. Unlike

the State employees in Supreme Court Reporters, the Medicaid health care providers, here, have no contractual right of reimbursement and thus, the lag in payment does not impair the State's contract obligations in violation of Article I, Section 10, clause 1 of the U.S. Constitution.

Finally, inasmuch as the payments are at the established rate and well within the 12 month statutory requirement, and apply to all Medicaid providers, governmental and nongovernmental alike, the delay violates no constitutional rights of appellants. It does not constitute a taking without just compensation; neither does it violate due process of law or the Equal Protection Clause.

We agree with the District Court's

determination that appellants failed to show a likelihood of success on the merits. We also conclude that appellants failed to demonstrate sufficiently serious questions going to the merits and a balance of hardships tipping decidedly toward appellants. Resolution Trust Corp. v. Elman, 949 F2d 624,626 (2d Cir. 1991). Accordingly, the order of the District Court denying the preliminary injunction is affirmed.

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF NEW YORK

UNITED CEREBRAL PALSY ASSOCIATIONS OF NEW YORK STATE, INC.,

Plaintiff, 91-CV-1438

-against-

MARIO CUOMO, as Governor of the State of New York, CESAR A. PERALES, Commissioner, New York State Department of Social Services, DALL FORSYTHE, Director, New York State Division of Budget, ELIN HOWE, Commissioner of New York State Office of Mental Retardation and Developmental Disabilities, LORNA McBARNETTE, Commissioner of New York State Department of Health,

Defendants.

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CON. G. CHOLAKIS, D.J.

MEMORANDUM DECISION AND ORDER

This action involves the initiation, by the New York State Department of Social Services ("DSS"), of a "lag" in the reimbursement of Medicaid funds to certain health care providers. Under this "lag," each payment by the State to the providers will be delayed by one day until the payments are ultimately received by the provider two weeks later than had been the practice prior to the implementation of the "lag."

The Medicaid Program, established pursuant to title XIX of the Social Security Act, 42, U.S.C. Section 1396 et seq., establishes a joint federal and state cost-sharing system to provide necessary medical services to indigent persons who otherwise would be unable to afford such care. Although a state is not required to participate in the program, it

must, once it has decided to so participate, abide by the applicable federal statutory and regulatory scheme.

To become a participant, a State must submit, for approval by the Secretary of Health and Human Services ("HHS"), a plan for medical assistance. This "State Plan"

> is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV [of the CFR], and other applicable official issuances of the Department.

42 C.F.R. Section 430.10 (1990). Once the is approved by HHS, the State is entitled to receive reimbursement from the federal government for a percentage of the funds the State pays to certain health care providers for the care provided to Medicaid recipients.

Plaintiff United Cerebral Palsy Associations of New York State, Inc. ("UCPA") is a not-for-profit provider that operates Intermediate Care Facilities ("ICFs") and approximately 70 community residences for the mentally retarded and developmentally disabled, under licenses of the New York State Office of Mental Retardation and Developmental Disabilities ("OMRDD"). UCPA also operates Diagnostic Treatment Centers under licenses of the New York Department of Health ("DOH"). Finally, UCPA provides transportation services to its clients. Although not totally clear from the papers, UCPA and its affiliates appear to serve over 30,000 clients in the State.

Proposed Intervenor St. Lukes-Roosevelt Hospital ("St. Lukes") is a not-for-profit hospital corporation located in Manhattan, with 1,300 patient beds, 6,500

employees, "and hundreds of renowned physicians, residents and medical students." Proposed Intervenor's Complaint par. 5. According to St. Lukes, it is the largest non-governmental provider of care to Medicaid patients in the State, with 40% of its inpatient days paid by Medicaid in 1990. See id. par. 8.

Plaintiff UCPA has brought on this Order to Show Cause for a preliminary injunction to prevent the State from continuing the lag. Plaintiff argues that the lag (1) violates the Boren Amendment to the Medicaid Act; (2) constitutes a taking of property without just compensation and without due process; (3) denies plaintiff equal protection; (4) violates other aspects of the federal Medicaid statutory and regulatory scheme; and (5) violates the rulemaking requirements of the N.Y. A.P.A. Proposed

Intervenor St. Lukes seeks (1) to intervene; and (2) a preliminary injunction preventing the continuation of the lag. Oral argument on the Order to Show Cause was held on January 31, 1992, at which time this Court issued an oral ruling denying the motion for an injunction, and informed the parties that this opinion would issue soon thereafter.

Intervention

St. Lukes first seeks to intervene as of right, and in the alternative, by permission. Defendant has not opposed this motion. Intervention as of right may be secured

> when the applicant claims an interest relating to the property or transaction which is the subject of the action and the applicant is so situated that the disposition of the action may as a practical matter impair or impede the applicant's ability to protect that interest,

> unless the applicant's interest is adequately represented by existing parties.

Fed.R.Civ.P. 24(a)(2).

The Second Circuit has held that a proposed intervenor must satisfy four criteria to be allowed to intervene as of right under Rule 24(a)(2). The proposed intervenor must (1) file timely, (2) demonstrate an interest in the action, (3) show an impairment of that interest arising from an unfavorable disposition, and (4) have an interest not otherwise adequately protected. See United States v. State of New York, 820 f.2d 554, 556 (2d Cir. 1987).

Because this Court finds that St. Lukes has satisfied the four-part test, and because the motion is unopposed, the Court hereby grants the motion to

intervene.

Preliminary Injunction

To obtain a preliminary injunction, the moving party must show (a) irreparable harm, and (b) either likelihood of success on the merits, or a sufficiently serious question going to the merits to make them a fair ground for litigation and a balance of the hardships tipping decidedly toward the party requesting the relief. See, e.g., The Resolution Trust Corp. v. Elman, 949 F2d 624, 626 (2d Cir. 1991); Paulsen v. Colunty of Nassau, 925 F. 2d 65, 68 (2 Cir. 1991). A Court's grant or refusal of an interlocutory injunction must set forth the findings of fact and conclusions of law which constitutes the grounds for its action. Fed.R.Civ.P. 52(a).

Plaintiff UCPA argues that the

"withholding" of one week's payment will result in a loss of $750,000 to UCPA, and $3 million to UCPA and its 25 New York State affiliates and divisions. See Parker Aff. par 23. UCPA contends that the lag will have a devastating impact on special education, clinical, health and other therapeutic services, vocational rehabilitation, residential services, family and community services, etc. See id. par. 29. Moreover, UCPA states that, as a result of the "reduction," it will be unable to comply with Medicaid quality control regulations and conditions and standards of participation. See id. par 30. UCPA further asserts that the result of the unavailability of cash "may be closure of residential programs, day treatment programs, recreation programs, and other services, layoff of staff, a lessening of the quality of programs for mentally retarded and developmentally

disabled residents of New York State." Id. par. 32. Finally, UCPA states that, "because of the uncertainties surrounding the state budget, plaintiff has been unable to secure additional loans from banks.. Id. par. 31.

St. Lukes predicts similarly dire consequences, stating that each week of "withholding" will result in a loss of $3.4 million. See Balko Aff. par. 41. St. Lukes states that, in order to maintain operations, it has already delayed payment to its vendors for 109 days, "the maximum extent possible without being placed on a cash on delivery only payment basis or incurring significant and unreimburseable interest and penalty costs." Id. par. 42. Further delay "will force the Hospital to cease to use certain suppliers who provide products that are preferred in patient care." Id. par.43.

In addition, St. Lukes' largest expense, a weekly payroll alternating between $4 and $6 million, cannot be delayed. See id. par 44. St. Lukes further asserts that the "withhold" will force dramatic cuts in services, e.g., further reduction in clinic hours, closure of additional clinics, refusal to treat clinic patients from outside its service area, and renegotiation or elimination of governmental contracts subsidized by the hospital. See id. par 45. These actions will lead to more layoffs and personnel cutbacks. See id. St. Lukes also states that patient access to care will be greatly affected.

Because this Court decides that UCPA and St. Lukes have not demonstrated a likelihood of success on the merits of their claims, the Court will not reach the issue of irreparable harm.

Boren Amendment

The first argument raised by UCPA and St. Lukes is that the lag, repeatedly characterized by them as a "permanent withholding" or a "reduction,"[1] violates the "Boren Amendment" to the Medicaid Act, because the lag constitutes a change in the methods and standards of payment for which the State has required, and failed,

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[1]It is alleged that the lag is a "withholding" because the providers will only get the money due them for those two weeks when "plaintiffs or other agencies go out of business." Pl. Mem. at 16; see also Parker Aff. par. 24 ("plaintiff would only receive this money if and when it closed its doors and ceased doing business."); Balko Aff. par. 35 ("The hospitals will receive the 'withheld' payments only when they cease to provide Medicaid services--which can only happen when they cease to treat patients."). Intervenor St. Lukes also equates "permanently withhold[ing] payments" with "pay[ing] less than anticipated." Proposed Intervenor's Mem. at 21.

The lag is characterized as a "reduction" by asserting that, since the providers will receive only 50 checks for 52 weeks of service for the fiscal year, the actual rate of payment is hereby "reduced." See, e.g., Proposed Intervenor's Mem. at 43 ("the permanent withholding will effect 4% reduction in the reimbursement rates for 1992"); id. at 41-42 n. 14 ("[T]he State is ...requiring health care providers to provide services for which the reimbursement rate would be zero.").

to make findings and then make assurances to the Health Care Finance Administration ("HCFA")[2],[3].

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[2]Under the relevant portion of the statute, a state plan under Medicaid must provide

> for payment ... of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State ...) and which, in the case of hospitals, take into account situation of hospitals which serve a disproportionate number of low income patients with special needs...which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and assure that individuals eligible for medical assistance have reasonable access...to inpatient hospital services of adequate quality....

42 U.S.C. Section 1396a(a)(13)(A) (emphasis added).

[3]The regulations provide as follows:

> (a) State assurances. In order to receive HCFA approval of a State plan change in payment methods and standards, the Medicaid agency must make assurances satisfactory to HCFA that the requirement set forth in paragraphs (b) through (g) are being met, must submit the related information required by Section 447.255 [which requires detailing the "amount of the estimated average proposed payment rate for each type of provider...and the amount by which that

In Pinnacle Nursing Home v. Axelrod, 928 F.2d 1306 (2d Cir. 1991), a case heavily relied upon by both plaintiff and the intervenor, the Second Circuit affirmed that portion of a District Court decision which held that New York's

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decreased relative to the average payment rate in effect for each type of provider for the immediately preceding rate period"], and must comply with all other requirements of this subpart.

(b) Findings. Whenever the Medicaid agency makes a change in its methods and standards, but not less often than annually, the agency must make the following findings:

(1) Payment rates. (i) The Medicaid agency pays for inpatient hospital services and long-term care facility [which includes ICFs, see 42 C.F.R. Section 447.251] services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

(ii) With respect to inpatient hospital services--

(A) The methods and standards used to determine payment rates take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs....

42 C.F.R. Section 447.253 (emphasis added).

"Adjustment" of a reimbursement methodology was enacted without complying with federally mandated procedures under the Medicaid Act. In Pinnacle, New York had adopted, as part of its 1986 Medicaid plan, the Regional Direct Input Price Adjustment Factor ("RIPAF"), under which the average wage rate for facilities within each of the State's 16 regions was calculated for the base year of 1983, and every facility reimbursed based upon the "average wage rate" within the region, regardless of actual wage rates at a particular facility. See Pinnacle Nursing Home v. Axelrod, 719 F. Supp. 1173, 1176 (W.D.N.Y. 1989).

The RIPAF was fully approved by HCFA. See id. at 1177. Ten months after the 1986 RIPAF methodology had been implemented, however, New York's Department of Health ("DOH") advised the

nursing homes throughout New York that the 1986 RIPAF would be altered by the "1987 Adjustment to RIPAF." See Pinnacle, 928 F.2d at 1310. This "Adjustment" created a "statewide positive or negative 10% corridor" around the previously established regional average wage rates, and provided that all nursing homes whose actual 1983 fell within the specified "corridor" would no longer be reimbursed based on the regional average wage rate, but rather upon a portion of each facility's actual reported 1983 wage rate. See id.

The effect of the "Adjustment" was to benefit those facilities whose higher labor costs resulted from historical factors beyond their control, as well as any other high-cost residential nursing home facility, regardless of the cause of its respective high costs, at the expense

of lower-cost facilities. See id. at 1311. Put another way, some facilities would receive more money than that to which they were entitled under the 1986 RIPAF methodology, while others would receive less.

The State contended that the "Adjustment" was not a "significant change" since it was budget neutral, affecting not the amount of Medicaid funds, but merely its allocation. The State therefore contended that the "Adjustment" was not an amendment which required prior notice to and approval of HCFA as required by 42 C.F.R. Section 447.253. HCFA disagreed, but, upon notification by New York that assurances which had been submitted to HCFA in support of an unrelated change in New York's Medicaid plan also constituted assurances in support of the "Adjustment,"

HCFA approved the Adjustment retroactively.

The District Court found a procedural violation but not a substantive violation of the Medicaid Act, and summarily dismissed the substantive claim "[i]n deference to the federally mandated priority of the states to determine their own Medicaid plans." Id. at 1312.

In affirming this holding, the Circuit held that the statutory language clearly requires that the State make findings that its reimbursement rates are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities," see 42 U.S.C. Section 1396(a)(13)(A), prior to making the "assurances" to HCFA that its Medicaid plan complies with Federal requirements. The procedural requirements

of the Boren Amendment, therefore, are not "mere surplusage." 928 F.2d at 1313; see also, Wilder v. Virginia Hosp. Ass'n, ___U.S.___, 110 S.Ct. 2510, 110 L.Ed.2d 455, 469 n.11 (1990).

Pinnacle makes clear that, where there is a change in payment methods and standards, the procedural steps in the governing regulations are mandatory. Unfortunately, in the present case, it does not appear that the lag is a change in "payment method and standards." Although plaintiff and the intervenor repeatedly state, in a conclusory way, that the lag is in reality a "withholding" and a "reduction," such characterized is simply using the conclusion to create premises.

As pointed out in the defendants' brief, neither plaintiff nor the

intervenor cite any statute regulation, case law, or even a portion of the State Plan requiring the State to make Medicaid payments in 10 business days as has been the past practice. Plaintiff cites and selectively quotes the federal regulation governing timely processing and payment of claims, omitting the portion that shows the inapplicability of regulations to the present controversy.[4] A cursory reading of

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[4]The regulation cited by plaintiff provides:

> (d) Timely processing of claims.
>
> * * *
>
> (2) The agency must pay 90 percent of all clean claims from practitioners, who are in individual or group practices or who practice in shared health facilities, within 30 days of the date of receipt.
>
> (3) The agency must pay 99 percent of all clean claims from practitioners who are in individual or group practices or who practice in shared health facilities within 90 days of the date of receipt.
>
> (4) The agency must pay all other claims within 12 months of the date of receipt, except in the following circumstances [none of which is relevant here]....

42 C.F.R. Section 447.45(d)(2)-(4). Plaintiff omitted the types of entities in subparagraphs (2) and (3), and has not stated that its facilities come within the scope of those subparagraphs.

that regulation reveals that the State is required by federal law to make payments on clean claims within 12 months of the date of receipt of such claims. Even with the two-week lag in effect, then, the State payment schedule, under which the providers will be paid within 28 calendar days of submitting claims, is well within the limits set by the federal regulation.

Defendants have provided a case which is virtually on all fours with the present controversy. In Illinois Council on Long Term Care v. Bradley, 759 F. Supp. 1309 (N.D.Ill. 1991), plaintiffs nursing homes and health care association brought an action for declaratory and injunctive relief against the direct of the Illinois Department of Public Aid ("IDPA"), the Illinois Medicaid agency, as well as the Comptroller and Treasurer of the State of Illinois. Plaintiffs sought a preliminary

injunction, claiming that the slowdown in Medicaid reimbursements to nursing homes violated the Medicaid Act and implementing regulations. Id. at 1310.

The IDPA had established monthly billing cycles, and had an historical median delay of approximately 30 days between receipt and commencement of processing claims, with an additional 30 day delay before reimbursement was paid to the providers. See id. In fiscal years 1989 and 1990, however, the first 30 day period increased to 40 days. In fiscal 1991, November 1990 services were reimbursed between 80 and 90 days after presentation of the claim, and December services were reimbursed over 100 days later. See id. at 1310-1311.

Plaintiffs alleged, as do UCPA and St. Lukes in the present case, that such

delays violated the "methods and standards" regulation discussed supra. The Court rejected this position, and refused to issue the requested injunction. To emphasize the parallels with the present case, much of the Illinois District Court's opinion is quoted here:

> [I]t is the State Plan which must comply with 42 U.S.C. Section 1396a(a), and not the "practices," "intentions," or "expectations" of the agency and the providers. Plaintiffs' allegations of a slowdown simply constitute a change in practice by IDPA. A new practice, even one that imposes great hardships on Medicaid providers, that does not violate the provisions of the State Plan cannot, by itself, cause the Plan to contravene the federal requirements with which the Plan has been found to comply.
>
> Plaintiffs contend that, by paying in a slower manner than was previously the practice of IDPA, the agency has violated 42 C.F.R. Section 447.253(a) and (b). [see discussion supra].
>
> * *
>
> An agency does not encounter the requirements of 42 C.F.R. Section 447.253(a) and (b) unless a change

has been made to the state plan's "methods and standards." Throughout this subpart of the federal regulations, the term "methods and standards" relates to payment rates ....Thus, unless the IDPA slowdown amounts to a change in the "methods and standards" of payment rates, IDPA is not required to make the assurances and findings specified in 42 C.F.R. Section 447.253(a) and (b).

Plaintiffs equate delayed payments with reduced payments, which would constitute a change of rates under the State Plan. However, plaintiffs cite no authority for this position. Most of the cases cited by plaintiff pertain to actual rate changes. The remainder involve rate freezes. None of the cases concern delays in reimbursement without alleging that the actual payment rates used by the state agency are different form those set out in the state plan. Plaintiffs make two arguments to equate the slowdown to a rate reduction. First, plaintiffs claim that the slowdown is tantamount to a decision by the IDPA to make no payments for November and half of December, 1990. Second, plaintiffs try to equate the slowdown to a rate reduction of 12.5 percent for 1990. Both of these positions would be correct if IDPA had taken the posture that no reimbursement for services rendered during that one and a half month period would be forthcoming. However, the circumstances are to the contrary. <u>IDPA has not denied liability for that period, and has stated that it plans to reimburse</u>

> plaintiffs for that period at the rates and in the time frame set forth by the State Plan. At this point, plaintiffs are unable to, and have no reason to, disprove this assertion. Thus, plaintiffs' attempts to equate delayed payment with reduced payment are unpersuasive.

Id. at 1312-1313 (emphasis added).

This Court finds the rationale of the Bradley court to be persuasive. The only element present in Bradley that is missing in this case is whether there is any provision in New York's State Plan relating to the timeliness of payment. Neither side has cited any portion of the State Plan.

Absent a showing that the State Plan would be violated by the lag here at issue, UCPA and St. Lukes have failed to demonstrate a likelihood of success on the merits with respect to the Boren Amendment claim. As in Bradley, UCPA and St. Lukes have not established that the lag is a

change in the "methods and standards of payment." Also as in Bradley, the cases cited by the UCPA and St. Lukes all involve actual percentage reductions in amounts paid or other the implementation of "caps" or suspension or elimination of incentive allowances. See, eg., Temple University v. White, 941 F.2d 201 (3d Cir. 1991), cert. denied sub nom., Snider v. Temple University, 60 U.S.L.W. 3472, 1992 WL 3005 (January 13, 1992) (invalidating, inter alia, 14% rate reduction based on a "budget neutrality adjustment", for failure to comply with 42 U.S.C. Section 1396(a)(13)(A)); Association of Surrogates and Supreme Court Reporters Within the City of New York v. State of New York, 940 F.2d 766, 769 (2d Cir. 1991), cert. denied, 60 U.S.L.W.___, 1992 WL 6769 (January 21, 1992) (invalidating, under Contract Clause of the federal Constitution, a lag program where a two

week lag phased in by paying 9 days' pay for ten days' work, and where uncompensated days would be paid to employees "at the termination of their employment with the state."); West Virginia University Hospitals, Inc. v. Casey, 885 F.2d 11 (3d Cir. 1989), aff'd, ____ U.S. ___, 111 S.Ct. 1138, 113 L.Ed.2d 68 (1991) (invalidating state plan where out-of-state hospitals reimbursed on basis of average payments to in-state hospitals, without accounting for disproportionate share of Medicaid patients and without making requisite findings); AMISUB (PSL), Inc. v. State of Colorado Department of Social Services, 879 F.2d 789 (10th Cir. 1989), cert. denied, ___U.S. ___, 110 S.Ct. 3212, 110 L.Ed.2d 660 (1990) (invalidating state's new reimbursement plan which resulted in cutting providing reimbursement by 46% across the board); Wisconsin Hospital Ass'n v. Reivitz, 820

F.2d 863 (7th Cir. 1987) (invalidating 1.8% reduction in reimbursement); Nebraska Health Care Ass'n, Inc. v. Dunning, 778 F.2d 1291 (8th Cir. 1985), cert. denied, 479 U.S. 1063 (1987) (invalidating HCFA's approval of "cap" on reimbursement where sufficient findings not made, therefore no factual basis for "assurances" made to HCFA); St. Tammany Parish Hospital Services District v. Department of Health and Human Resources, 677 F. Supp. 455 (E.D.La. 1988) (findings emergency rule creating 10% reduction of interim Medicaid reimbursement rates to violate 42 C.F.R. Section 447.253); Association of Surrogates and Supreme Court Reporters Within the City of New York v. State of New York, ___N.Y.2d ___, 1992 WL 5676 (January 16, 1992) (invalidating, under the Contract Clause of the federal Constitution, a payroll lag where deferred wages "to be paid in lump sums when the

employees' service is terminated, either by retirement or death, at the basic annual salary in effect at that time."); Matter of Quirk v. Regan, 148 Misc.2d 300, 565 N.Y.S.2d 422 (Sup.Ct. Albany Co. 1991) (invalidating payroll lag under federal Contract Clause); McDermott v. The Unified Court System of the State of New York, RJI #01-90-ST2725 (Sup.Ct. Albany Co. 1991) (finding collateral estoppel effect of Quirk); see also federal and state cases cited at Proposed Intervenor's Mem. at 24.

Further, as in Bradley, UCPA and St. Lukes argue that the State will never pay the providers for the two weeks during which they will not receive a check. The State maintains that the providers will certainly be paid, just at a later date. Similarly, plaintiff and the intervenor characterize the lag as a "reduction," but

without authority and, therefore, without force.

For the foregoing reasons, the Boren Amendment argument advanced by plaintiffs is insufficient to warrant the issuance of an injunction.

Taking Without Due Process of Law and Just compensation

Because the "taking" arguments of both UCPA and St. Lukes are based upon the underlying premise that the delay is a permanent withholding and a change in the rates of reimbursement, which presumption is not, in this Court's opinion, correct, the taking arguments must fail as well.

This Court recognizes that "New York acknowledges a property interest in money paid for services already performed in

reliance on a duly promulgated reimbursement rate." Oberlander v. Perales, 740 F.2d 116, 120 (2d Cir. 1984). Were the present case to involve, as did Oberlander, a rate revision or a change in rates, the arguments advanced by UCPA and St. Lukes might have some force.

In the present case, however, there is no taking, much less one without just compensation or due process of law. Plaintiff merely argues that the state cannot "limit or reduce" the rates of Medicaid reimbursement solely due to budgetary considerations, and cannot alter plaintiff's "property right in reimbursement for the services rendered" without due process of law.

This court has already determined that the delay is not a "reduction" in payment; nor is it a "limitation."

Plaintiff will be paid in full, pursuant to the already extant rate of reimbursement, albeit received two weeks later than had been the practice prior to the implementation of the lag. Plaintiff's property interest has not been "taken." [5]

Intervenor argues that, because state law requires hospitals to provide emergency care to persons regardless of ability to pay or source of payment, the state has "taken" private property and must therefore provide just compensation. Assuming, without deciding, that such state law constitutes a taking, intervenor

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[5]Even assuming, arguendo, that the delay were a taking, plaintiff received both notice and an opportunity to be heard. Plaintiff was first notified of the impending delay by letter dated August 13, 1991. See Mastrototaro Aff. Par. 14. All affected providers were given an opportunity to be heard as will. See id. the delay was rescheduled to begin later than originally planned. See id. par. 15.

has not demonstrated that the amount of money paid pursuant to established rates is not "just compensation" but, by again characterizing the delay as "confiscatory" and "fail[ure] to pay." Failure to pay, as well as inadequate payment, may constitute a lack of just compensation. Neither plaintiff nor intervenor, however, has demonstrated to this Court that there is a property interest in the time of payment. Nor has any statutory or regulatory provision, case law, or provision in the State Plan, been cited to support the position that payment is required to be at a particular time.

The Court therefore declines to issue an injunction based upon the foregoing "taking" arguments.

Equal Protection

Plaintiff argues that the delay, targeting only nongovernmental providers, thereby violates its rights to Equal Protection under the federal and state Constitutions. In response, defendant, through an affidavit of Ben Mastrototaro, Associate Commissioner for Medicaid Centralized Operations in the New York State Department of Social Services, states that the delay applies to all Medicaid providers, both governmental and nongovernmental, which are paid through the Medicaid Management Information System ("MMIS"). See Mastrototaro Aff. par. 20. In reply, plaintiff asserts, that, unlike the ICFs it operates, which are paid through the MMIS, the state-operated ICFs are not paid through the MMIS. Therefore, argues plaintiff, "defendants have in fact

singled out providers such as UCPA for the permanent withholding." Parker Reply Aff. par. 16.

Plaintiff has not demonstrated to this Court, as it must for the issuance of a preliminary injunction, that it is likely to succeed on the merits of its Equal Protection claim. Plaintiff has not shown that the delay, which targets a particular payment system, not a particular type of provider, lacks a rational basis or fails to further a legitimate government interest. This argument is unavailing.

Finally, to the extent the UCPA and St. Lukes claim state law grounds to support the issuance, by this Federal Court, of an injunction, such relief is barred by the Eleventh Amendment. See Pennhurst State School and Hospital v.

Halderman, 465 U.S. 89, 106 (1984) ["I]t is difficult to think of a greater intrusion on state sovereignty than when a federal court instructs state officials on how to conform their conduct to state law. Such a result conflicts directly with the principles of federalism that underlie the Eleventh Amendment.").

The Court therefore makes the following findings of fact:

(1) Plaintiff United Cerebral Palsy Associations of New York State, Inc. ("UCPA") is a not-for-profit provider that operates Intermediate Care Facilities ("ICFs") and community residences for the mentally retarded and developmentally disabled, under licenses of the New York State Office of Mental Retardation and Developmental Disabilities ("OMRDD").

UCPA also operates Diagnostic Treatment Centers under licenses of the New York State Department of Health ("DOH"), and provides transportation services to its clients.

(2) Proposed Intervenor St. Lukes-Roosevelt Hospital ("St. Lukes") is a not-for- profit hospital corporation located in Manhattan, with 1,300 patient beds, 6,500 employees St. Lukes and is one of the largest nongovernmental provider of care to Medicaid patients in the State.

(3) By letter dated August 13, 1991, the New York Department of Social Services ("DSS") informed plaintiff of the initiation of a delay in payment of Medicaid checks by one week, to be gradually phased in by delaying the payments one day per week. Under the original delay as described in that

letter, no check would be received by plaintiff during the week of December 10, 1991 to January 3, 1992. Such check would be received one week later.

(4) By subsequent letter, providers were informed that the week during which no check would be received had been changed to the week of February 3-7, 1992.

(5) By letter dated January 6, 1992, DSS informed providers that a second week-long delay would be instituted, as a result of which no check would be received during the week of march 16-20, 1992. This second delay would be phased in by delaying checks one day per week during the months of February and March.

(6) One week's Medicaid payments to plaintiff UCPA and its 25 New York state affiliates and divisions is approximately

$3 million.

(7) One week's Medicaid payments to intervenor St. Luke's-Roosevelt Hospital is approximately $3.4 million.

(8) The delay has in fact been implemented, with the first week-long delay planned for week of February 3-7, 1992.

The Court makes the following conclusions of law:

FIRST: UCPA and St. Lukes have not demonstrated a likelihood of success on the merits of their claim that the Medicaid payment lag is a change in the methods and standards of payment implicating the "findings" and "assurances" requirements of 42 U.S.C. Section 1396a(a)(13)(A) and 42 C.F.R.

Section 447.253(a) & (b).

SECOND: UCPA and St. Lukes have not demonstrated a likelihood of success on the merits of their claims that the Medicaid payment lag is a taking of their property without just compensation and/or due process of law.

THIRD: Plaintiff has not demonstrated a likelihood of success on the merits of its claims that the Medicaid payment lag denies it equal protection of the law under the federal Constitution.

FOURTH: To the extent UCPA and St. Lukes rely upon alleged violations of state law by the defendants in support of the motion for an injunction, such relief is barred by the Eleventh Amendment.

FIFTH: The Court, having declined to

issue a preliminary injunction on the ground that movants have failed to demonstrate a likelihood of success on the merits of their claims, does not reach the issue of irreparable harm.

SIXTH: The Court grants St. Lukes-Roosevelt Hospital's motion to intervene in this action.

IT IS SO ORDERED:

CON G. CHOLAKIS

CON. G. CHOLAKIS,
JUDGE
UNITED STATES DISTRICT
COURT

DATED: February 3, 1992
Albany, New York

(2)

No. 92-463

Supreme Court, U.S.
FILED
NOV 4 1992
OFFICE OF THE CLERK

IN THE

Supreme Court of the United States

October Term, 1992

UNITED CEREBRAL PALSY ASSOCIATIONS OF NEW YORK STATE, INC.,

Petitioner,

against

MARIO CUOMO, as Governor of the State of New York; ELIN HOWE, as Commissioner of the New York State Office of Mental Retardation and Developmental Disabilities; MARK R. CHASSIN, as Commissioner of the New York State Department of Health; MARY JO BANE, as Commissioner of the New York State Department of Social Services; PATRICK BULGARO, as Director of the Budget,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

RESPONDENTS' BRIEF IN OPPOSITION

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(2515—LC7-582—1992)

BEST AVAILABLE COPY

Counterstatement of the Question Presented

Whether, in view of the fact that 42 C.F.R. § 447.45(d)(4) requires payment of Medicaid claims to petitioner within 12 months of the receipt of properly submitted claims, and there is no other applicable provision in the Boren Amendment of the Medicaid Act, its implementing regulations, or the State Medicaid Plan, which requires that Medicaid payments be made sooner, on any particular date or within any particular time period, no review by this Court is called for where this Court recently denied a writ for certiorari in the only other case which reached the same conclusion on the identical legal issue.

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No. 92-463

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1992.

UNITED CEREBRAL PALSY ASSOCIATIONS OF NEW YORK STATE, INC.,

Petitioner,

against

MARIO CUOMO, as Governor of the State of New York; ELIN HOWE, as Commissioner of the New York State Office of Mental Retardation and Developmental Disabilities; MARK R. CHASSIN, as Commissioner of the New York State Department of Health; MARY JO BANE, as Commissioner of the New York State Department of Social Services; PATRICK BULGARO, as Director of the Budget,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

RESPONDENTS' BRIEF IN OPPOSITION

Respondents Mario Cuomo, Elin Howe, Mark R. Chassin, Mary Jo Bane, and Patrick Bulgaro respectfully request that the Court deny the petition for a writ of certiorari

seeking review of the Second Circuit's denial of petitioner's request for a preliminary injunction to prohibit New York State from sending out Medicaid payments 14 days later than the payments had previously been sent.

Statement of the Case

The Statement of the Case offered by petitioner contains certain factual inaccuracies and erroneous conclusions of law. Accordingly, a brief Statement of the Case is offered by respondents.

The State, assisted by the federal government and federal funding under the Medicaid Program (42 U.S.C. § 1396, *et seq.*), reimburses providers enrolled in the program for the cost of rendering medical care to qualified patients. Providers submit their claims to the Medicaid Management Information System ("MMIS") after services have been rendered. Such claims are processed, and if approved as valid, a check for payment is issued and released to the provider.

Petitioner erroneously contends that only nongovernmental providers are reimbursed through the MMIS. The MMIS is responsible for the processing of payment of Medicaid reimbursement to both governmental and nongovernmental Medicaid providers for services rendered to Medicaid recipients.

In 1991, due to fiscal constraints, and with prior notice to petitioner and the other providers, the State implemented a delay in Medicaid payments. Ultimately, a 14-day delay in checks was gradually implemented over a five month period

of time so that by the end of the State's 1991-1992 fiscal year, on March 31, 1992, the MMIS payments were sent out within 28 days of the receipt of properly submitted claims.

As a result of this delay there were two weeks in which no Medicaid checks were released; however, contrary to petitioner's statements, no withholding of payment occurred. The State continued to reimburse providers such as petitioner for those two weeks, but only on a slightly more delayed schedule than before. Petitioner was and is still being paid for all services rendered and at the established rate of payment. Medicaid checks continue to be sent out on a weekly basis for bills submitted 28 days earlier.

Petitioner additionally makes contentions in the section in its petition entitled "Effect of Permanent Payment Delay on Petitioner" which are factually unsupported. While petitioner's complaint and declarations submitted to the district court contained conclusory speculations about the future effect of the 14-day delay in payments, there was no factual evidence below that the petitioner in fact lost vendors, cut programs and services, and laid off therapists, clinicians and other employees, and that, if this occurred, it was the result of the delay in payments.

REASONS FOR DENYING THE WRIT

There is no reason warranting the grant of a writ of certiorari here. This Court has recently denied certiorari in a case presenting the same legal issue. The interlocutory order and decision of the court below do not conflict with this Court's interpretation of the Boren Amendment, other Courts of Appeals' decisions, and the express language of the relevant statutes and regulations. The order and underlying decision below were correctly decided and there is no other reason for granting a writ of certiorari.

Petitioner seeks to review the Second Circuit's interlocutory order denying petitioner a preliminary injunction ordering quicker reimbursement. The Second Circuit held that petitioner is not likely to succeed on the merits of its claims that the State's additional 14-day delay in Medicaid reimbursement (or payment of Medicaid claims within 28 days after the receipt of properly submitted claims) violates the Medicaid Act and its regulations. The court below, in denying petitioner's request for injunctive relief, agreed with the reasoning of the Seventh Circuit in *Illinois Council on Long Term Care v. Bradley,* 957 F.2d 305 (7th Cir. 1992), *cert. denied,* ____ S. Ct. ____, 61 U.S.L.W. 3256 (October 5, 1992). *Illinois Council* is the only other case the parties are aware of which presented the identical legal issue for review, although the State's delay in Medicaid reimbursement there was more extensive than the two week delay at issue here. This Court recently denied petitioners' request for a writ of certiorari in *Illinois Council* and there is no reason to rule otherwise here.

There is no conflict, direct or otherwise, between the Second Circuit's holding and this Court's decision in *Wilder v. Virginia Hospital Association*, 496 U.S. 498 (1990), and the decisions in other circuit courts. All petitioner's arguments are based on the erroneous assumption that the Boren Amendment of the Medicaid Act applies to the date a Medicaid check is sent, notwithstanding that neither that statute nor its implementing regulations say anything about the date of payment.[1] As the Second and Seventh Circuits found, "the Boren Amendment requires that the *rates* of payment established by the State be adequate; there is no requirement as to the *date* of payment. On its face, the statute does not impose time limits or refer to timeliness in any way." Appendix A, p. 8.

Title 42 C.F.R. § 447.45(d)(4) sets forth time schedules for the payment of Medicaid reimbursement and requires only that payment of Medicaid claims to providers such as petitioner be made within 12 months of the receipt of properly submitted claims. Petitioner is receiving Medicaid reimbursement for all services rendered and at the established rate of payment within 28 days of the receipt of properly submitted claims, well within the permissible limits of 42 C.F.R. § 447.45(d)(4).

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[1]Petitioner erroneously contends that the State's delay in Medicaid payments is a reduction in the amount of payment. The Court below rejected this argument. Appendix A, pp. 9-10. To the extent petitioner bases this claim on *Association of Surrogates & Supreme Court Reporters v. New York*, 940 F.2d 766 (2d Cir. 1991), *cert. denied*, ____ U.S. ____, 112 S. Ct. 936 (1992), and other cases which concerned the State's salary lag, petitioner assumes that the delay in Medicaid payments was implemented in the same manner as the State's salary lag of its employees. This is not the case. There is no factual evidence in the record below to support this assumption.

None of the cases cited by petitioner in which a violation of the Boren Amendment was found deal with the timeliness of Medicaid payments; they concern changes in the rate of Medicaid payments. *See, e.g., St. Tammany Parish Hospital Dist. v. Dept. of Health & Human Resources,* 677 F. Supp. 455 (E.D. La. 1988) (Emergency rule creating a 10% reduction in interim Medicaid reimbursement rates violated 42 C.F.R. § 447.253). *Wilder v. Virginia Hospital Assn.,* 496 U.S. 498 (1990), did not deal with the adequacy of Medicaid rates at all; the issue there was whether health care providers could enforce substantive federal rights under the Boren Amendment by bringing an action pursuant to 42 U.S.C. § 1983. *Wilder* said nothing about the timeliness of Medicaid payments.

The only cases cited by petitioner which concern the timeliness of payments do not involve the Boren Amendment. The courts in those cases found a violation of the Medicaid Act because the states were using their financial problems as an excuse to violate express federal statutory provisions and regulations which, unlike this case, required payment in 30 days. See *Ohio State Pharmaceutical Assn. v. Creasy,* 587 F. Supp. 698 (S.D. Ohio 1984), and *Massachusetts General Hospital v. Sargent,* 397 F. Supp. 1056 (D. Mass. 1975). Respondents here, even after the delay, will be making payments within 28 days.[2]

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[2]Even if, in contradiction to 42 C.F.R. §447.45(d)(4), a "prompt payment" requirement was assumed to be implicit in the Boren Amendment as petitioner suggests, the State's payment within 28 days would still be in compliance with such a requirement. Payment within 28 days would presumably be deemed "prompt payment" given that the shortest payment requirements in the Medicaid Act cited by petitioner provide for payment within 30 days of the receipt of proper claims.

The only decision which deals with the issue in this case is *Illinois Council* which is fully consistent with and supported by the rationale of the Second Circuit's decision. The supposed "conflict" among the court decisions, upon which petitioner bases its argument in support of granting the writ, does not exist. To the contrary, petitioner's interpretation that the Boren Amendment regulates the date of Medicaid payment, if accepted, conflicts with the express language of 42 C.F.R. § 447.45(d)(4), which requires that Medicaid payments be made within 12 months, and other provisions of the Medicaid Act. According to petitioner, Congress has amended other provisions of the Medicaid Act to require payments in 30 days and yet has chosen not to include providers such as petitioner within those amended provisions. *See, e.g.*, 42 U.S.C. § 1396n(b) (4).

Since the date of payment is not the same as the rate of payment, the Second Circuit's decision does not conflict with the other statutory and regulatory provisions cited by petitioner. Because the Boren Amendment only refers to changes in the rate of Medicaid payments, the regulations which implement the amendment also just refer to changes in the rate of Medicaid payments and not to this case. As the court below found, "[t]he regulations implementing the Boren Amendment, 42 C.F.R. Section 447.250, *et seq.*, refer only to adequate rate setting and say nothing about the date on which payment must be made. Where the regulations *do* speak of time requirements, 42 C.F.R. Section 447.45(d)(4), that provision requires that the Medicaid agency pay all claims within 12 months of the date of receipt. New York's 28 day repayment scheme is obviously within this." Appendix A, pp. 8-9.

Moreover, the change in date of Medicaid payments does not constitute a change in "payment methods and standards" so as to require the State to make findings and assurances pursuant to 42 C.F.R. § 447.253. As the court below held, "a change in the date of payment does not equal a change in the rate of payment, New York has not altered its methods and standards for setting rates, and thus the State has no obligation to make assurances or findings under this section." Appendix A, p. 12.

Finally, the delay in Medicaid reimbursement does not constitute a "material change in State law, . . . or in the State's operation of the Medicaid program" so as to require that the State amend its State Medicaid Plan under 42 C.F.R. § 430.12(c). The State Plan does not contain any additional requirements for timely processing of Medicaid claims for payment other that the 12-month requirement, and the State's payment is within that provision.[3]

There is thus also no conflict, direct or otherwise, between the Second Circuit's decision and the intention of Congress and the Executive Branch as expressed in the statutes and regulations petitioner cites.

For the reasons set forth above, the Second Circuit correctly decided this case. The Court determined it was unnecessary to review this identical legal issue arising in an interlocutory order only a month ago in *Illinois Council*, and there is no reason to do so now.

[3]Petitioner claims that the State's action knows of no limit or constraint and that the State could thus impose up to a year delay in payment. There is no evidence that the State intends to implement such delay. Moreover, since the State gets enhanced federal funds by complying with a 30-day time limit, there is no incentive for the State to go beyond the 30 days. Lastly, this is not a basis for giving petitioner the relief it requests. Any such claim is more appropriately made to Congress with a request to amend the Boren Amendment.

CONCLUSION

The petition for a writ of certiorari should be denied.

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Respectfully submitted,

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